



ADULT/COLLEGE Volunteer Program

Becoming part of the NUMC volunteer team is a process and has many steps. Please review all the information carefully as there are several requirements and procedures that should be considered.

The following steps are required:

1. The volunteer application
2. The credit report/background check form
3. Review and sign the commitment and expectation form
4. Mail back the above information- address info below.
5. You will be contacted once your application has been received to set up an interview.
6. Volunteers are required to make a *100 hour commitment* for the year.
7. Once your application has been received and reviewed you will be contacted to set up an interview (usually via email so please print your email address clearly).
8. After the interview you will be contacted as to whether you have been accepted into the Volunteer Program.
9. Please note that if you are accepted into the Volunteer Program you will need to have a health assessment with NUMC medical forms signed and stamped by your own physician. ***You may wish to start this process***, forms have been included:
 - a. This includes copies of immunizations or titers
 - b. Proof of 2 recent PPD (tuberculin skin test)
 - c. These two items must be brought to the NUMC Employee Health Center (open from 12:30pm-3:30pm, M-F, Building E, Room 132) You will receive a clearance form from Employee Health. Please submit this form to Volunteer Services.

Please do not bring these items to the Employee Health Center until you have been accepted into the program. However, this step must be completed prior to Orientation.

10. Orientations are scheduled monthly.
11. Please note we can not guarantee any positions in particular departments.

Completed Applications should be returned to: Linda Walsh, Director of Volunteer Services
By Mail: Nassau University Medical Center
Department of Volunteer Services- Box 6
2201 Hempstead Turnpike, East Meadow, NY 11554
c/o Linda Walsh

We look forward to meeting you! If you have any questions please do not hesitate to contact Volunteer Services at 516.572.6588 or by email at lwalsh@numc.edu.

DEPARTMENT OF VOLUNTEER SERVICES
 THE NASSAU UNIVERSITY MEDICAL CENTER
 2201 HEMPSTEAD TURNPIKE BOX 6
 EAST MEADOW, NY 11554 (516) 572-6588



Adult/College Volunteer Application

Volunteering begins with a commitment. At The Nassau University Medical Center we encourage all volunteers to serve at least 4 hours a week for at least 8 months. Before an assignment can be made, each volunteer must obtain medical clearance from his/her physician, be seen by the Employee Health Center, be interviewed and attend an orientation program Please print clearly and complete the entire application. Please be sure to provide an accurate email address!

THIS APPLICATION SHOULD BE COMPLETED BY THE APPLICANT!

NAME: LAST	FIRST	MIDDLE	DATE
------------	-------	--------	------

ADDRESS	HOME TELEPHONE #:
	CELL #:

CITY	STATE	ZIP CODE	SOCIAL SECURITY #:
			YOU MUST PROVIDE A SS#

PLEASE LIST ANY RELATIVES OR FRIENDS WHO ARE EMPLOYEES OR VOLUNTEERS AT THE NASSAU UNIVERSITY MEDICAL CENTER (INCLUDE NAME, DEPARTMENT AND RELATIONSHIP.)

DATE OF BIRTH	EMAIL ADDRESS – PLEASE PRINT CLEARLY!:
---------------	--

ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF HOURS PER WEEK	SUPERVISOR:
---	-----------------------	-------------

JOB TELEPHONE #:	COMPANY NAME AND JOB TITLE:
------------------	-----------------------------

VOLUNTEER EXPERIENCE:
 SERVICE DATES, LOCATIONS, VOLUNTEER DUTIES

TO BE NOTIFIED IN CASE OF EMERGENCY NAME	RELATIONSHIP
---	--------------

EMERGENCY CONTACT PHONE # (HOME)	EMERGENCY CONTACT PHONE # (CELL)
----------------------------------	----------------------------------

PERSONAL PHYSICIAN

ADDRESS AND TEL. #

WILL YOU BE DRIVING TO THE NASSAU UNIVERSITY MEDICAL CENTER: IF YES, PLEASE COMPLETE THE FOLLOWING:
 YES NO

MAKE OF CAR:	MODEL:	COLOR:	LICENSE PLATE NO.:	YEAR:
--------------	--------	--------	--------------------	-------

ARE YOU UNDER MEDICAL TREATMENT OF ANY KIND:
 YES NO

IS YES, PLEASE EXPLAIN

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT MIGHT AFFECT YOUR VOLUNTEERING?

YES NO

IF YES, PLEASE EXPLAIN

PLEASE LIST FOREIGN LANGUAGES THAT YOU SPEAK FLUENTLY:

SPECIAL SKILLS THAT MIGHT BE USEFUL IN YOUR VOLUNTEER WORK:

CLUBS OR ORGANIZATIONS TO WHICH YOU BELONG:

PLEASE IDENTIFY SPECIFIC TIMES WHEN YOU WOULD BE ABLE TO VOLUNTEER:

NOTE: You must be available for at least 4 hours per week

1) List all possible hours (Please DO NOT indicate: anytime/all day)

OR List day/evening preference

2) List shift length preference (ex: 4 hour shifts)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

ARE THERE ANY PARTICULAR DEPARTMENTS THAT INTEREST YOU?

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Out Patient (HBO) | <input type="checkbox"/> ER | <input type="checkbox"/> Maternity | <input type="checkbox"/> Green House | <input type="checkbox"/> Mailroom |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Library | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Surgical Units | <input type="checkbox"/> Laundry | <input type="checkbox"/> Information | <input type="checkbox"/> Bedside | <input type="checkbox"/> Computer Support |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Public Affairs | <input type="checkbox"/> Medical Units | <input type="checkbox"/> Surgical Waiting Rooms | <input type="checkbox"/> Dietary |
| <input type="checkbox"/> Stockroom | <input type="checkbox"/> Therapeutic Recreation | <input type="checkbox"/> Clerical | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Outpatient Clinics | <input type="checkbox"/> Employee Health | <input type="checkbox"/> Pre-Admission | <input type="checkbox"/> EMS | <input type="checkbox"/> Physical Med & Rehab |
| <input type="checkbox"/> OR Waiting Room | <input type="checkbox"/> Radiology | <input type="checkbox"/> Ambulatory Breast Imaging | <input type="checkbox"/> Grounds | <input type="checkbox"/> Other: _____ |

WHEN WILL YOU BE ABLE TO START?

WHY DO YOU WANT TO VOLUNTEER AT THE NASSAU UNIVERISTY MEDICAL CENTER?

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM AT THE NASSAU UNIVERSITY MEDICAL CENTER?

PLEASE INCLUDE 3 NON-RELATED REFERENCES

NAME	ADDRESS	PHONE NO.

I AGREE THAT AS A VOLUNTEER I WILL:

➤ FOLLOW THE COMMITMENT AND EXPECTATIONS OF THE NUMC VOLUNTEER PROGRAM

➤ ATTEND A MANDATORY TRAINING SESSIONS BEFORE I BEGIN TO VOLUNTEER

APPLICANT SIGNATURE:

X

DATE:

Volunteer Commitment and Expectations

Welcome to the Nassau University Medical Center (NUMC) Thank you for volunteering. We feel that before you formally agree to volunteer at NUMC you should understand what is expected of you. Please consider this information a basic guide, the commitment and expectations of all volunteers. More information is outlined in the Volunteer Orientation Manual.

1. As an NUMC Volunteer one agrees to abide by the following and to accept and perform their volunteer duties within the following confidentiality guidelines as well as to follow all mandatory HIPAA rules and regulations.
2. Student Volunteers must attend a training session before they begin volunteering. Trainings are offered periodically and include, but are not limited to, information on infection control, HIPAA regulations, etc...
3. Information regarding diagnosis and/or treatment of any patient receiving services from NUMC whether inpatient or outpatient should not be discussed or repeated. Searching for or disclosing any information found on patients' charts will be considered a breach of confidentiality.
4. Volunteers may not disclose the fact that a patient is or is not receiving services as a patient or an out patient. If a person wishes for their neighbors, religious community, employers, or fellow employees to know they have been hospitalized or undergoing treatment, they must inform such persons themselves. Any disclosure of patient's status will be considered a breach in confidentiality.
5. Volunteers may not disclose information regarding financial status of any person who is a patient at or receiving treatment from NUMC. Searching for, or disclosing financial information about any patient, will be considered a breach in confidentiality.
6. If necessary, more intensive training will be provided by the department in which the volunteers will be working in.
7. Volunteers must punch in at the beginning of their shift and punch out at the end.
8. Volunteers are expected to be dressed appropriately with their assigned uniforms and ID badges. Neatness, hygiene and professionalism are of the utmost importance.
9. NUMC reserves the right to discontinue any volunteer to any particular department at any time if it is felt that your skills and ability would be better suited for a different volunteer opportunity. NUMC also reserves the right to discontinue participation in the volunteer program at any time. As a volunteer one can be terminated for breach of confidentiality, failure to obey Hospital rules and regulations; and for actions that are deemed not in the best interests of the Hospital.
10. After the completion of orientation all student volunteers will be expected to make a 100-hour a year commitment.

11. It is our understanding in the NUMC Volunteer Department that volunteers often have busy schedules, but we do ask that if one should commit to any of our opportunities that they contact the Coordinator of Volunteer Services as soon as possible if they will be unable to attend or meet that commitment. Our volunteer's dependability, reliability and follow through are of the utmost importance.

12. All volunteers are asked to conduct themselves in a punctual, conscientious way, with dignity and respect for all patients, staff, visitors and people within the hospital and its grounds.

13. Volunteers are asked to abide by policies, procedures, supervision and directions of the Volunteer Services Department which includes all placements, schedules, assignments and responsibilities, etc...

14. Volunteers may not at anytime participate in observation of clinical services; including but not limited to, direct patient care.

15. Volunteers at all times must uphold the standard, ethics and mission statement of the Nassau University Medical Center.

16. Volunteers are expected to attend any scheduled NUMC volunteer service meetings.

17. Volunteers must attend annual in-service trainings on "mandatory" topics as outlined in the Volunteer Orientation Program Manual.

18. Annually, all volunteers must receive a mandatory tuberculin skin test, at no cost through the Employee Health Center or from their own physician.

19. All volunteers are expected and asked to maintain open communication with the Volunteer Services Department.

20. Volunteers must return their ID badge upon completion of their volunteer services.

21. There is a \$20 charge for the mandatory volunteer uniform.

22. As a volunteer one is expected to uphold the NHCC values at all times.

○ **CREATE A POSITIVE IMPRESSION**

First impressions are lasting impressions.

○ **ANTICIPATE AND RESPOND**

Take the initiative to meet needs and exceed expectations.

○ **RESPECT**

Value the opinion of others and appreciate each other's contributions and diversity.

○ **INTEGRITY AND COMPASSION**

We perform our jobs in an ethical manner, with honesty, sincerity, and compassion for others.

○ **NEAT-CLEAN-SAFE**

We pride ourselves on providing a safe and healing environment.

○ **GOING ABOVE AND BEYOND**

Set high standards and strive to be the best.

If you have any questions or concerns please feel free to discuss them with the Director of Volunteer Services. Volunteers make a difference everyday.

Volunteer Signature _____ Date _____

DEPARTMENT OF VOLUNTEER SERVICES
THE NASSAU UNIVERSITY MEDICAL CENTER
2201 HEMPSTEAD TURNPIKE BOX 6
EAST MEADOW, NY 11554
(516) 572-6588



Adult/College Volunteer Application

NUHEALTH
FAIR CREDIT REPORTING ACT
DISCLOSURE AND AUTHORIZATION FOR
CRIMINAL BACKGROUND CHECK

Thank you for your interest in participating in the Volunteer Program at the Nassau Health Care Corporation (“NHCC”). Please read the following disclosure carefully and sign the authorization below:

In order to make a determination as to your suitability for the Volunteer Department with NHCC, NHCC will obtain from a “consumer reporting agency” a “consumer report” on you which details your criminal background. These terms are defined in the Fair Credit Reporting Act (“FCRA”), a Federal law which applies to you. As an applicant with NHCC, you are a “consumer” with rights under the FCRA.

BACKGROUND SCREENING Authorization

By signing below, I, _____, hereby voluntarily authorize NHCC to obtain from a “Consumer reporting agency” a “consumer report” about me detailing my criminal background. I understand that information obtained in the consumer report may be used by NHCC in making a program participation decision. I further understand that failure to consent to the release of a consumer report detailing my criminal background will render me ineligible for consideration at NHCC.

Signature

Date

I, _____, of my own free will, without any promises of immunity or coercion, agree to allow Nassau Health Care Corporation to conduct a criminal background investigation on myself in connection with my application at Nassau Health Care Corporation.

I hereby release, waive, and forever discharge each of the above named corporations, firms, their respective agents, employees and any of my former employers and all actions or cause of action, claim, demand or liability which I have now or may have resulting directly from conducting this background investigation.

First Name _____ Middle Initial _____ Last Name _____
Street Address: _____ City _____ State _____ Zip _____
Drivers License # _____ State _____
Date of Birth _____ Social Security _____

Signature: _____ Date: _____ Telephone _____

DEPARTMENT OF VOLUNTEER SERVICES
THE NASSAU UNIVERSITY MEDICAL CENTER
2201 HEMPSTEAD TURNPIKE BOX 6
EAST MEADOW, NY 11554
(516) 572-6588



Adult/College Volunteer Application

NUHEALTH

Employee Health Services: Physician Attestation Instructions for N employees

New York State Department of Health Regulations 405.3(b) requires all healthcare personnel to have a physical examination and recorded medical history to ensure there is no health impairment that would pose a potential risk to patients.

Please have the attached **Physician Attestation** completed, **signed** and **stamped** by your healthcare provider.
YES, YOU NEED ALL OF THE BELOW INFORMATION!

Immunity is required for **measles/rubella/mumps**. A person is considered immune if they have a documented vaccine history (detailed below)

- 1) 2 doses of live **MMR** vaccine on or after the first birthday and separated by at least 28 days.

OR

- 1) 2 doses of live **measles** vaccine on or after the first birthday and separated by at least 28 days **AND**
- 2) 1 dose of live **rubella** vaccine administered on or after the first birthday **AND**
- 3) 2 doses of live **mumps** vaccine administered on or after the first birthday and separated by at least 28 days.

OR

Laboratory confirmation of immunity (**most desirable and preferred**).

Varicella: Evidence of immunity includes:

- 1) documentation of 2 doses of **varicella** vaccine at least 28 days apart
- OR**
- 2) laboratory confirmation of immunity (**most desirable and preferred**).

TWO documented **Tuberculin Skin Tests (PPDs)**. One recent AND one within one year. Or TWO recent. **EVEN IF YOUR OWN PHYSICIAN WILL NOT GIVE YOU TWO PPDs BACK TO BACK- THEY ARE STILL REQUIRED!** Those persons with a **positive TST** are required to submit proof of a **chest x-ray** done within the last year.

PLEASE COMPLETE THE ENTIRE FORM AND REVIEW CAREFULLY- EMPTY SPACES OR MISSING INFORMATION WILL RESULT IN NON CLEARANCE.

The completed Physician Attestation AND medical form may be returned to the Employee Health Office Room E 132

Monday through Friday 12:30 p.m. – 3:30 p.m.



DO NOT RETURN THE FOLLOEING FORM WITH YOUR APPLICATION PACKET - ONLY IF YOU HAVE BEEN ACCEPTED – PLEASE BRING THIS FORM TO THE ABOVE OFFICE AND RETURN ONLY THE CLEARANCE FORM RECEIVED FROM EMPLOYEE HEALTH TO VOLUNTEER SERVICES. KEEP A COPY FOR YOUR OWN RECORDS!

IF YOU HAVE QUESTIONS REGARDING THESE MEDICAL FORMS PLEASE CONTACT EMPLOYEE HEALTH DIRECTLY AT 516.572.6308 ONLY!



DO NOT RETURN THIS FORM TO VOLUNTEER SERVICES or with your application – PLEASE BRING IT TO NUMC EMPLOYEE HEALTH – RM E-132, M-F, 12:30PM-3:30PM.

IF YOU HAVE QUESTIONS REGARDING THESE MEDICAL FORMS PLEASE CONTACT EMPLOYEE HEALTH DIRECTLY AT 516.572.6308 ONLY!

**NUHEALTH
NASSAU UNIVERSITY MEDICAL CENTER**

Employee Health Services: Physician Attestation for N employees

Name print last/first: _____ / _____

Address print: _____

Date of Birth: ____/____/____

Below to be **completed, signed** and **stamped** by a Licensed Practitioner:

Proof of immunity to Measles, Mumps, Rubella

#1 MMR vaccine _____	Measles vaccine #1 _____ #2 _____
#2 MMR vaccine _____	Mumps vaccine #1 _____ #2 _____
	Rubella vaccine _____

Rubella virus IgGAb titer results (attached) _____
 Rubeola virus IgGAb titer results (attached) _____
 Mumps virus IgGAb titer results (attached) _____

Proof of immunity to Varicella

#1 Varicella vaccine _____	Varicella virus IgGAb titer results (attached) _____
#2 Varicella vaccine _____	

Proof of immunity to Hepatitis B

#1 Hepatitis B vaccine _____	HepBsAb results (attached) _____
#2 Hepatitis B vaccine _____	Refused Hepatitis B vaccine series _____
#3 Hepatitis B vaccine _____	

2 Step Tuberculin Skin Test (PPDs- please complete both sections)

TST #1 (recent) Date _____	TST #2 (within 1 yr. of application) Date _____
Date evaluated _____	Date evaluated _____
Result: _____ mm induration	Result: _____ mm induration

Has a positive reaction to the TST. A **chest X-Ray** report is required (**within the year**) (attached).
 Review of symptoms: persistent cough, fever, chills, unexplained weight loss, night sweats, coughing up blood, loss of appetite, prolonged fatigue. Does the above named have any of these symptoms? (please circle) NO YES

* I have performed a physical examination of sufficient scope to ensure that the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior (per N.Y.S. Code 405.3(b)).

Practitioner's signature: _____

Practitioner's name(print): _____

Address: _____

License #: _____ State: _____ Phone #: (____) _____

Date this certificate was completed: ____/____/____

Practitioner's Stamp:

THIS FORM MUST BE COMPLETE AND STAMPED -PLEASE REVIEW